STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	03/10/2011

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STERLING HOUSE OF SOUTH BEND	17441 STATE ROAD 23 SOUTH BEND, IN46635

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R0000	This visit was for a State Licensure Survey. Survey Dates: March 7, 8, 9 and 10, 2011 Facility Number: 010667 Provider Number: 010667 AIM Number: N/A Survey Team: Toni Krakowski, RN, TC Vicki Manuwal, RN Bobbie Costagan, RN Census Bed Type: Residential: 35 Total: 35 Census Payor Type: Other: 35 Total: 35 Sample: 8 Supplemental Sample: 7 These state residential findings are cited in accordance with 410 IAC 16.2-5. Quality review 3/16/11 by Suzanne Williams, RN	R0000	The following is the Plan of Correction for Sterling House of South Bend in regards to the Statement of Deficiencies for the annual survey completed on 3-10-11. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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R0006	Based on observation, interview, and record review, the facility failed to provide the necessary supervision to prevent numerous falls for a resident who required total assistance with transfers and toileting. This deficient practice affected 1 of 2 residents reviewed for scope of residential care in a sample of 8. Resident: #34 Findings include: During observation of the noon meal in the main dining room on 3/07/11 at 12:40 P.M., Resident #34 was observed being transferred from her wheel chair to her dining room chair by R.A. (Resident Aide) #3. Resident #34 was unable to bear any weight on her legs to assist R.A. #3 with the transfer. R.A. #3 used a transfer belt around Resident #34's waist but was unable to transfer the resident without actually holding her up by the	R0006	R 006 Scope of Residential Care *What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?* · Resident #34: Responsible party will be notified by the Executive Director of the need to provide a 24 hour sitter for provision of 1:1 supervision due to fall risk and lack of safety awareness. If unable to provide, will assist with obtaining assessments by a skilled nursing facility or memory care unit to facilitate a transfer. ***How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?*** · Health and Wellness Director / Designee will review residents for changes in condition, using the existing Collaborative Care Review process to ensure resident needs are met through the use of the Personal Service System assessment and Personal Service Plan. · Resident Fall records will be audited by the Health and Wellness Director/Designee for interventions and trends, and additional follow-up will be documented on the Personal Service Plan. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance**	04/09/2011

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	waistband of her slacks causing her slacks to be pulled taught into her groin. R.A. #3 managed to set Resident # 34 on the very edge of the chair, but Resident # 34's legs could not support her weight and resulted in R.A. #3 grabbing Resident # 34 from her backside under each arm and across her chest to pull her into the seat of the chair. Review of Resident # 34's clinical record on 3/07/11 at 2:50 P.M. indicated diagnoses including, but not limited to, macular degeneration, hypertension, and dementia. Interdisciplinary Progress Notes (Nurse's Notes) indicated the following falls over the past 6 months: "8/12/10 at 12:30 P.M.-Resident fell at 12:25 P (P.M.)...Resident found near her door in a sitting position...8/13/10 at 4:15 P.M.-Res. (Resident) found on floor by BR (bathroom) in room...9/20/10 at 3:50 P.M.-Res.		**programs will be put in place?** · Twice monthly, the Leadership Team (Executive Director, Health and Wellness Director, Dietary Manager, and Life Enrichment Coordinator/Designees) will meet and review the health status of residents during the Collaborative Care meeting. Minutes from this meeting will be sent monthly to the Regional Director of Clinical and Resident Services for discussion and review.***By what date will these systemic changes be implemented?*** · 4-9-11	

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	found on hands & knees by apt. (apartment) door by another res. Res. states she 'fell out of bed and crawled to the door'...9/23/10 at 9:30 A.M.-Observed sitting on floor next to wheel chair...9/24/10 at 3:30 P.M.-Res. found on bottom by coffee table...9/29/10 at 5:00 P.M.-Res. was found sitting on the floor between her bed & closet...9/30/10 at 7:15 P.M.-Res. attempting to ambulate & transfer self from W/C (wheel chair). D/T (due to) unsteady gait & extreme swollen legs she lost balance & scooted all the way to the floor. There is patient's decrease in mobility & frequent falls in the past week or so...10/06/10 at 5:00 P.M. -Unable to find Res. to give her medicine. Asked R.A. if she had seen Res. States they just brought her down to DR (dining room) in W/C. Not currently in DR. R.A. went to look for Res. and found by W/C in front of apt. door...10/14/10 at 11:15 P.M.-Call to apt. (number) by CNA. Found pt. (patient) sitting			

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	on floor in front of W/C. Res. could not explain what happened...10/16/10 at 2:55 P.M. -R.A. called this nurse to Res. room stating she 'just fell'...11/05/10 at 2:30 P.M.-I went into (Name) room to take depends family brought & found Resident on the floor siting on her bottom next to her bed...11/12/10 at 3:20 P.M.-Res. found on floor in between couch & coffee table... 11/12/10 at 10:45 P.M.-R.A. called to this nurse stating Res. about to fall. On entering room R.A. had lowered Res. to floor to assist Res. falling. Res. had gotten out of bed by self...11/14/10 at 5:40 P.M.-Res. found on floor by bed trying on shoes...11/26/10 at 5:45 P.M.-Res. found sitted (sic) on the floor bridged between the foot of the bed and her wheel chair...11/28/10 at 11:25 (P.M.)-Resident was on floor next to the bed when R.A. was doing rounds...11/29/10 at 10:00 P.M.-At approx (approximately) 4:15 P.M. (Name of R.A.) found			

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	Resident sitting on floor on her bottom between her bed & bathroom, apparently trying to assist herself to the bathroom...12/2/10 at 4:15 P.M. -Activities Director found Res. on floor near door. Res. had been knocking on inside of her door for help...12/2/10 ay 5:30 P.M.-This nurse across room in DR saw Res. at last second when she was attempting to stand up on her own reaching for her W/C which was out of reach & was leaning too far & the chair she was sitting in toppled over & Res. landed on floor...1/1/11 at 3-11 (P.M. shift) -Res. came out of room was in hallway slid to floor before nurse could reach her. Res. has sm. (small) skin tear to R (right) inner hand...1/21/11 at 10:00 P.M.-R.A. noted Res. alarm sounding & Res. on floor on her bottom...Res. had gotten up without assist x's (times) 4 earlier...Assisted x's 4 back to bed...Res. forgettful (sic) & continues to get up per self without			

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	assist though too weak to get from one area to another...2/17/11 at 3:30 P.M.-Res. got out of bed without assist. Slid to floor...3/4/11 at 7:50 P.M.-Res. found on floor in hall near old apt. Res. attempted to get up per self...." Review of the Interdisciplinary Progress Notes from 8/12/10 through 3/04/11 indicated a total of 23 falls. The Fall Management Investigations indicated: "...9/21/10-Falls have occurred when resident unattended, attempts transfers & becomes unsteady. Poor cognition=poor safety awareness...refer to therapy for ? tx. (treatment)...9/23/10-Refer to PT (Physical Therapy)...10/05/10-Continues with unsteady gait, making attempts to ambulate independently. Continues with confusion and poor safety awareness...Res. getting more & more weak & hard to do			

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	everything-decreasing in all ADL's (activities of daily living), ambulation unsteady...PT/evaluated and did not pick-up for services...10/14/10-Order received to be fitted for personal W/C...11/15/10-Resident uses low bed (since 11/12/10)...Resident uses wheelchair alarm (added 11/15/10)...12/03/10-New wheelchair is in place...." Resident #34 was observed being transferred from her wheel chair to her dining room chair on 3/09/11 at 12:50 P.M. R.A. #5 placed a transfer belt around the waist of Resident # 34 and attempted to lift the resident from her wheel chair. Resident #34 was unable to bear any weight on her legs (knees were bent and legs collapsed) as R.A. #5 struggled to get her into the dining room chair. During interview with the Wellness Director on 3/09/11 at 3:50 P.M., she indicated Resident # 34's falls			

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	have decreased since she received her new wheel chair and had her bed lowered. However, Resident # 34 continued to sustain falls, as indicated in the above mentioned Interdisciplinary Progress Notes, after each of the interventions. Review of Resident # 34's most recent Personal Service Assessment, printed 1/13/11, indicated, "...Bathing Assistance: ...Do you need help to use the bathroom? Yes; ...Do you need help because you are unable to use bathroom on your own? Examples include pulling up and down pants, handling toilet paper, wiping, changing protective undergarments and getting onto and off of toilet. Yes; ...." Further review of the Personal Service Assessment indicated, "...Are you unable to stand independently while using the bathroom needing weight-bearing or balance assistance from one associate? No...." However, Resident # 34 was observed unable			

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	to bear any weight to assist with transfers as indicated above. The Personal Service Assessment, printed 1/13/11, further indicated, "...Escort and Mobility...Comments: Able to walk; Needs reminders for call light use... Encourage wake time in common areas and life enrichment secondary to falls risk...." Resident #34 was observed in her bed on the following dates and times: 3/07/11 during the initial tour of the facility at 10:25 A.M., 3/07/11 at 3:12 P.M., 3/08/11 at 10:50 A.M. and 3:56 P.M., and 3/09/11 at 10:15 A.M. Resident #34 was not observed in the common area during the three days of the survey other than dining room meals. An Assessment Summary Report, printed 1/13/11, indicated Resident # 34 required assistance and the fee for each: "...Bathroom Assist: Help			

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	because resident is unable to use the bathroom on their own...." Resident # 34 is being charged a monthly fee for this service. A facility policy titled "Falls Management Program," undated, indicated, "...Falls are the number one cause of injury related death for people over 65...Falls can have serious consequences for the resident. Injuries caused by falls reduce quality of life, decrease the resident's ability to function, and increase the resident's risk of death...Problems: Unsafe transfer and mobility without staff assistance-studies show that many residents fall when trying to transfer or walk alone. Interventions: Each resident should be assessed carefully. If the resident uses any equipment (walker, wheelchair, cane) it is best to assess him or her when using the equipment. Observe resident walking, transferring, getting in and out of the bed and chair...getting on			

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	and off of the toilet...the above information should then be addressed on the resident's Personal Service Plan and reviewed...This assessment should be done prior to or upon move in and with any change of condition...."			

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R0035	Based on interview and record review, the facility failed to ensure a resident's right to refuse PRN (as needed) pain medication was honored. This deficient practice affected 1 of 6 residents receiving PRN pain medication in a sample of 8. Resident: # 36 Findings include: Resident # 36's clinical record was reviewed on 3/08/11 at 10:30 a.m. and indicated diagnoses of, but not limited to: end-stage dementia, history of cerebrovascular accident (stroke), and anxiety. Review of Interdisciplinary Progress Notes (Nurse's Notes), dated 11/03/10 at 5:30 P.M., indicated, "Res. (resident) agitated when trying to give Morphine (pain medication). States 'I already had this 3 x's (times) today. I told them no more!' Res. turned to grab &	R0035	R 035 Resident Rights ***What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?*** · Resident #36 appeared to have no adverse effects related to placing her prn medication into applesauce. Due to her dementia, resident has exhibited agitation when her pain is not effectively managed. Resident is not consistently able to verbalize her discomfort. The LPN reports she often goes back after an initial refusal to offer medications at another time, to avoid having the resident's pain not being addressed. In this case, she reports going back to offer medications in a more palatable form, by placing in applesauce. The resident has a physician order in place which allows nursing to put medication in a food substance to make it easier to swallow. The nurse has been re-educated by the Health and Wellness Director on appropriate documentation for such circumstances, and to reinforce the need to respect resident's right to refuse medications. This resident's Personal Service Plan will be updated by the Health and Wellness Director to include appropriate interventions related to resident refusals of medications. ***How will the facility identify other residents***	04/09/2011

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	throw. Had to put in applesauce to get res. to take...." A Physician's Order, dated 6/10/10, indicated, "Morphine Solution 2.5 ml (milliliter) 5 mg. (milligram) P.O. (by mouth) q (every) 2 hours PRN (as needed)." During interview with the Wellness Director on 3/08/11 at 4:20 P.M., she indicated LPN #4 should not have given the pain medication to the resident if she refused it. "The Resident has a right to refuse medication."		***with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?*** · Other residents who receive medication administration services and refuse medications have the potential to be affected by the alleged deficient practice.· Existing policy states residents have a right to refuse medications. Associates may not disguise a medication in order to get a resident to take it unknowingly. In such cases, the associate is to notify the MD if refusals continue, in order to obtain appropriate medication instructions or obtain orders for medications in a more palatable form. When a resident refuses medications, the nurse is to document the refusal on the MAR by circling their initials in the corresponding box on the MAR and documenting the refusal on the back of the MAR, record any effects related to the refusal, document the refusal in the resident record, and dispose refused medications according to the Med Destruction Policy.· Nurses have received re-education on the above policy, provided by the Health and Wellness Director/Designee. **What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does**	

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			not recur? · The Health and Wellness Director/Designee will audit the MAR three times weekly for documentation of Medication refusals, and appropriate documentation of follow-up actions. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?** · The Health and Wellness Director will notify the Executive Director with audit results weekly, to report on compliance. The Executive Director will then make recommendations for corrective actions, if necessary, based on audit results. . **By what date will these systemic changes be implemented?** · 4-9-11	

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R0117	Based on interview and record review, the facility failed to ensure a minimum of one staff person with current certification in CPR (Cardiopulmonary Resuscitation) and First Aid were on duty at all times. This deficient practice had the potential to affect 35 of 35 residents residing in the facility. Findings include: Review of the 2/20 through 2/28/11 and 3/1 through 3/19/11 Nursing Staff Schedules indicated the following dates lacked a staff person on duty with a current certification in CPR/First Aid on the following dates and shifts: 2/20/11 from 10 P.M. to 6 A.M., 2/23/11 from 2 P.M. to 10 P.M. and 10 P.M. to 6 A.M., 2/24/11 from 10 P.M. to 6 A.M., 2/25/11 from 10 P.M. to 6 A.M., 2/26/11 from 2 P.M. to 10 P.M., 2/27/11 from 2 P.M. to 10 P.M., 2/28/11 from 10 P.M. to 6 A.M., 3/1/11 from 10 P.M. to 6 A.M., 3/4/11 from 10 P.M. to 6 A.M., 3/4/11 from 10	R0117	R 117-Personnel **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?** · No residents have been affected by the alleged deficient practice. ***How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?*** · Associate files and schedule will be audited by the Executive Director and Health and Wellness Director/Designee to determine associates in need of recertification.· CPR and First Aid recertification courses were held on 3-14-11 for associates found to be out of compliance. This training was provided by A Red Cross representative. Community is waiting on cards at this time-expected to take 7-10 days to arrive.· Attendance was mandatory for nurses and QMA's.· A tickler file will be utilized by the Executive Director/ Designee to monitor for due dates of additional certifications. . **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?** · Associate schedules will be reviewed by the Executive Director and Health and Wellness	04/09/2011

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	P.M. to 6 A.M., 3/5/11 from 10 P.M. to 6 A.M., 3/6/11 from 10 P.M. to 6 A.M. During an interview on 3/9/11 at 3:30 P.M. with the Wellness Director, she indicated that the Q.M.A. (Qualified Medication Aide) normally scheduled for the 10 P.M. to 6 A.M. shift was previously CPR/First Aid certified but it had expired and she is scheduled to renew the certification at a future date.		Director every two weeks to audit for compliance. · A "heart" symbol will be placed on the schedule next to the name of all associates whose certifications are current to allow for ease of review. **By what date will these systemic changes be implemented?** · 4-9-11	

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R0273	Based on observation and interview, the facility failed to ensure all food preparation areas were clean and sanitary related to improper storage of personal beverages, improper disposal of dirty mop water, improper storage of waste, and a dust buildup. The deficient practice had the potential to affect 35 of 35 residents who dine in the facility. Findings include: During a tour of the facility's kitchen conducted with dietary employee #1 on 3/7/11 at 10:15 A.M., the following observations were made: An open mug of coffee was observed sitting on the counter and an open can of diet Pepsi was in the refrigerator. There was a buildup of dust on the bottom of the door leading to the dining room, and behind the fire extinguisher. A large trash can half full of waste was left uncovered.	R0273	R 273 Food and Nutritional Services ***What corrective action(s) will be Accomplished for those residents found to Have been affected by the alleged deficient practice?*** · No residents have been affected by the alleged deficient practice. ***How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?*** · No resident have been affected by the alleged deficient practice.· Dietary Staff have been Re-educated on 3/8/11 and Instructed not to have personal drinks and items on kitchen work areas or in the refrigerators. Breaks are to be taken in break room.· Dietary Staff have been re-educated on how to properly follow daily cleaning schedule.· Dietary Staff has been Re-educated on 3/8/11 on the proper procedures on trash can use. Trash can lids to be on can at all times. · Dietary Staff was re-educated on 3/8/11, on procedures on the proper disposal of dirty mop water. A smaller mop bucket was purchased. ***What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?*** · Dietary Staff have been re-educated on 3/8/11 and	04/09/2011

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	During interview on 3/7/11 at 10:15 A.M. with dietary employee #1, she indicated the cup of coffee and can of diet Pepsi were her personal beverages. She also indicated that the trash can was typically kept covered. On 3/7/11 at 11:00 A.M., a mop bucket filled with dirty water was sitting next to the three compartment sink in the kitchen. Dietary employee #1 indicated in an interview on 3/7/11 at 11:00 A.M., that the mop bucket was always emptied into the three compartment sink instead of the utility sink because the bucket was too wide to fit in the door. Observation on 3/7/11 at 2:45 P.M., showed a build up of dust on the fans in the refrigerator. During interview on 3/7/11 at 4:30 P.M. with the Food Service Supervisor, she indicated personal beverages are not to be kept in the		Instructed not to have personal drinks and items on kitchen work areas or in the refrigerators. Breaks are to taken in break room.· Dietary Staff have been re-educated on how to properly follow daily cleaning schedule.· Dietary Staff have been re-educated on 3/8/11 on the proper procedures on trash can use. Trash can lids to be on can at all times. · Dietary Staff have been re-educated on 3/8/11 on procedures on the proper disposal of dirty mop water. A smaller mop bucket was purchased and will be dumped in the utility room.· As of 3/9/11. Maintenance now has refrigerator and freezer on monthly cleaning schedule. ***How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?*** · Food service Supervisor or designee will do random checks weekly to observe proper disposal of mop water and following daily cleaning lists. Personal food and drink procedures will be checked weekly and will be documented by Food Service Supervisor or designee. ***By what date will these systemic changes be implemented?*** · 04-09-11	

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	food service area and that dietary employee #1 had been previously inserviced regarding kitchen protocol. She also indicated that maintenance was scheduled to clean the refrigerator fans on 3/8/11.			

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R0298	Based on observation and interview, the facility failed to dispose of expired medications in a timely manner that were stored in the medication cart. This deficient practice had the potential to affect 2 of 29 residents who have administered medications. Residents: #13 and #19. Findings include: During inspection of the medication cart on 3/10/11 at 9:50 A.M., the following was observed: Resident #13: eight Meclizine (dizziness) 12.5 mg (milligrams), expired 1/25/11; Resident #19: 12 Acetaminophen (pain) 325 mg, expired 2/2/11. Interview with LPN # 2 on 3/10/11 at 9:50 A.M., she indicated that all nurses are responsible for checking the medication cart for expired drugs.	R0298	**R-298 Pharmaceutical Services** ***What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice?*** No residents were affected by alleged deficiency. Expired medications were removed from cart and destroyed. Nursing staff will be re-educated to check dates on medications prior to administering them during medication passes. ***How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?*** The medications for residents have been checked by the Health and Wellness Nurse and Nursing staff for dates of expiration and medications are correctly dated. Pharmacy will be informed of any findings. The Health and Wellness Director /and or designee will check medication cart once monthly for expired medications. There will also be a check system completed when new medications are delivered by the carrier for appropriated dates prior to acceptance of delivery. Medications will be destroyed for all discharged within seven days of discharge. ***How will the corrective actions be monitored to ensure***	04/09/2011

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	The Wellness Director indicated in an interview on 3/10/11 at 11:35 A.M., that the Pharmacy inspected the medication cart twice a year in April and October. The last inspection was 10/27/10.		***the deficient practice will not recur, i.e. what quality assurance programs will be put into place?*** This action will be monitored by the HWD and Designee through weekly at random audits. ***By what date will these systemic changes be implemented?*** 4/9/11	

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R0302	Based on observation and interview, the facility failed to label OTC (over the counter) medications with the proper identification information and dates the medication was opened. This deficient practice affected 3 residents (#1, #19, #29) in the sample of 8 and 4 residents (#8, #14, #21, #33) in the supplemental sample of 7 who received administered medications. Findings include: During inspection of the medication cart, on 3/10/11 at 9:50 A.M. with LPN # 2, the following items were observed mislabeled: Resident #1: One bottle of Fish Oil (vitamin supplement) 100 mg. (milligram)- lacked documentation of MD name on label; Resident #8: one bottle of Centrum Silver Ultra Women's (vitamin)- lacked documentation of Resident name and MD name on label; Resident #19: one bottle of St.	R0302	***R-302What corrective actions will be accomplished for those residents found to have been affected by alleged deficient practice?*** Resident #1, #19, and #29 were provided appropriate labels for OTC medication on the date of the survey. Nursing staff administering medication will be re-educated on proper labeling requirements for OTC medications. This will include Physicians Name, Resident's name, expiration date name of drug and strength. ***How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action wll be taken?Other residents who receive med administration services have the potential to be affected by the alleged deficient practice, therefore, the Health and Wellness Director and designee have completed a medication cart audit to ensure all OTC medications are appropriately labeled.***A letter or 1:1 discussion will be held between nurses and family members who supply medications from a third party provider, notifying them of the need for labels for all medications they provide, including OTC medications. Effective April 20th, families will be asked to have medications labeled by their	04/09/2011

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	Joseph 81 mg. (aspirin)- lacked documentation of Resident name and MD name on label; Resident #21: one bottle of Arthritis Pain 650 mg.- lacked documentation of Resident name and MD name on label and one bottle of Calcium 600 mg. (supplement)- lacked documentation of Resident name and MD name on label; Resident # 29: one bottle of TUMS (indigestion)- lacked documentation of Resident name and MD name on label; Resident #33: one bottle of Stool Softener 100 mg.- lacked documentation of MD name on label, Anti-diarrheal capsules 2 mg. - lacked documentation of MD name on label, one bottle of Complete Ultra Women's Health Senior (vitamin)- lacked documentation of Resident name and MD name on label and one bottle Clear Lax (laxative)- lacked documentation of Resident name and MD name on label.		pharmacy when purchasing over the counter medications prior to bringing them into the community and will be instructed to give medication to the nurse for review and placement into the med cart.***How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place? When receiving new medications from families or third-party provider, the nurse will check to ensure all OTC medications have a proper label upon arrival or will apply one prior to placing the medication in the cart.The Health and Wellness Director will assign cart audits to nurses on a weekly basis and will complete unannounced audits to determine compliance and make recommendations, based on findings.By what date will these systemic changes be implemented?4-9-11 How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e. what quality assurance programs will be put into place?*** This action will be monitored by the HWD and Designee through weekly at random audits. ***By what date will these systemic changes be implemented?*** 4-9-11	

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	During interview with LPN # 2 on 3/10/11 at 9:50 A.M., she indicated facility practice is to label OTC (over the counter) medications with the Resident's room number, Resident name, and MD name. On further inspection, at this time, the following lacked documentation of an open date: Resident #14: three vials of Ipratropium Bromide 0.5 mg. and Albuterol Sulfate 3.0 mg. solution (asthma medication). The vials were in a foil package with a sticker affixed indicating, "Discard 7 days after removal from foil pack." LPN #2 indicated, in an interview on 3/10/11 at 10:00 A.M., she was unsure when the package was opened.			